Illinois Uninsured State Planning Grant
Small Business Solutions

SUMMARY

The Illinois State Planning Grant project team is interested in expanding on its original ideas to reduce the number of uninsured by increasing the number of small businesses offering group insurance and the number of employees of small businesses taking the insurance offered by their employers.

In Illinois there are 1.2 to 1.7 million people (9.7% - 13.4%[1] of the population) who are uninsured. Of those, approximately 64%[1] (928,000) of the uninsured are employed, 61%[1] (885,000) of the uninsured are employed by firms with fewer than 50 employees and 53% of the uninsured do not have employer coverage offered to them. The percentage of employees offered coverage and the percentage actually covered drops dramatically in employers with fewer than 25 employees. The Medical Expenditure Panel Survey[2] (MEPS) estimates that in 1999, the majority of the employed uninsured are employed by firms with fewer than 25 employees. Affordability is the most frequent reason given for employers not offering insurance or for employees not electing coverage that is offered.

Since the reason most often given for lack of health insurance is affordability, this paper first provides background on the forces behind the rising cost of health insurance. Then three mechanisms are presented that could be used to provide better access to health insurance for small employers and their employees. These mechanisms could be implemented independently, but would be most effective if implemented in one coordinated approach. They include:

- A small business health insurance product structured to be affordable and attractive to employees,
- A small business purchasing pool structured to maximize cost effectiveness and participation, and
- A potential reinsurance mechanism to help mitigate the effect of high cost individuals.

Overview of Small Business Mechanisms

The small business product outlined here is structured as a high deductible product that covers preventive services with a small co-payment. Premiums, co-payment, and deductibles would vary based on income level. At very low income levels the product would provide basically first dollar coverage with a relatively small out-of-pocket cost. At the higher income levels the product would become a high deductible plan and the

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[1] HRSA Illinois State Planning Grant, *Final Report to the Secretary,* Pg. 1

2 Medical Expenditure Panel Survey, *Insurance Component.* April 2001. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/data_pub/ic_toc.htm

premiums are more typical for the product design. The product would reduce costs through contracted provider discounts. Individuals would have the choice to go to non-contracted out-of-network providers, but would pay higher out-of-pocket amounts even after maximum out-of-pocket expenses are met.

The purchasing pool mechanism differs in that it is intended to reduce costs through economies of scale and purchasing power. It is also hoped that state and federal funds would be available to subsidize premiums for low income and/or high-risk individuals. A limited number of payors would offer products through insurance brokers. The pool would have a small staff to support brokers and provide education to brokers, chambers of commerce, and small employer groups. Groups with 2 – 50 employees would be eligible to participate with a three-year commitment. After an initial open enrollment period, groups would be required to have previous insurance for at least one year before joining the pool.

A final proposed mechanism is a reinsurance pool. Health care costs are driven by a small percentage of individuals. It is estimated that 20% of the population drives 80% of the health care costs, with the cost of insurance being predominantly driven by these high cost individuals. Observation of actual claims data may differ some as seen in the data of one Wisconsin based insurer where 22% of the population had 84% of the claims, but observed experience is primarily close to the 80/20 estimate. If there were a way to fund the high cost population outside of insurance premiums, then premiums would become more affordable. Reinsurance cannot remove these high costs, but it can be a mechanism for smoothing premiums between high cost years and low cost years and among high cost groups and low cost groups. Reinsurance can mitigate the effect on premium increase that groups experience when they have a year with unusually high health care costs. It is also possible that state and federal funds available for low income and/or high risk individuals can be used to subsidize the reinsurance pool. In addition, it may be possible to employ a statewide assessment of all employers that would be used to subsidize the reinsurance pool to pay the cost of high risk individuals. For example, an assessment on all employees could be used to subsidize the health care coverage of all high risk individuals.

AFFORDABILITY OF HEALTH CARE AND HEALTH INSURANCE

Over 1 million or 77%[3] of the Illinois uninsured are under 185% of the federal poverty level (FPL) and only 172,000 (12%[3]) are over 250% of the FPL. Because of the high cost of health care, when individuals and families are uninsured they do not get the health care that they need. This is particularly a problem when conditions are not treated early resulting in increased health care needs and cost. Beyond the problem of increased cost due to untreated conditions, there is also a societal ideal that people have access to needed health care, but this is simply not always the case. In the past, access to health care has often been met by community hospitals, but now public or private insurance is the vehicle that provides individuals access to health care services that they need.

[3] HRSA Illinois State Planning Grant, *Final Report to the Secretary,* Pg. 6

As experts consider other mechanisms for making health care available to those in need, they invariably come to the conclusion that public and private insurance is the most efficient mechanism for the financing of health care. However, problems invariably exist. The biggest difficulty with insurance is that it has become unaffordable for many and even employers who offer it now are concerned about large premium increases. Employers wonder why health insurance premiums are increasing at 20% when inflation is at 3%. The answer to why the cost of health insurance is rising is that the cost of medical care is also increasing. The cost of medical care increases more every year because:

- The cost per service increases,
- More services are being used, and
- New services are being developed for the detection and treatment of health conditions.

More services are being used because of the aging population and increased demand stimulated by advertising. Advertising has had a large impact on health care costs by making the public aware of prescription drugs that are particularly effective in treating some chronic conditions such as allergies and asthma.

The increasing cost of health care isn't the only reason insurance has become so costly. In fact, insurance premiums can actually increase more than the overall cost of health care when the uninsured population uses health services more than the insured population. This happens when:

- Healthier individuals drop their insurance,
- More individuals with health problems become insured,
- Mandated benefits are required to be paid for by insurance,
- Individuals use more services because the insurance will pay for them (this exacerbates the effect of advertising, aging, etc. in the insured population),
- Efforts to reduce Medicare costs cause cost shifting to the insured population, and
- Younger individuals drop insurance while older individuals purchase insurance causing the average age of the insured population to be higher than the population in general.

Although little can be done about these rising costs, health benefit plans can be designed to get the most with the funds available. The three mechanisms discussed in this paper can be implemented separately or in combination. The small business product could be developed and offered in the small group market. This product could also be offered to a state sanctioned purchasing pool available to small businesses. With or without the specialized product or purchasing pool, a reinsurance mechanism could be developed to smooth out the cost of premiums from group to group and from year to year. The reinsurance mechanism could potentially be subsidized with state and federal funds that are available to support either low income or high risk individuals.

SMALL BUSINESS PRODUCT

A recurring theme in explaining the size of the uninsured population is the affordability of health insurance[4]. Some states have attempted to solve the affordability problem by offering "bare bones" products with reduced premiums[5]. However, employers and employees have not found these products attractive, because they still are quite costly and are perceived as having little value. In fact, the bare bones policies do not cover the benefits that individuals say they would use such as preventive services.

In order to be successful, a product must provide sufficient benefits that are seen as valuable and affordable. A significant number of employers and employees must purchase the product and continue coverage over time. The product must also be attractive to health plans and to the broker community. Insurance brokers are very important to small businesses that do not have employee benefit departments and need help understanding their options in a very complicated marketplace. It is often very time consuming and not profitable for brokers to work with small employers.

Affordability is relative to income. The average out-of-pocket expense, which can exceed $5,000[6] for a family of three, is too high for low income individuals. Annual income at 185% of FPL is $15,892 for an individual and $27,066 for a family of three[7]. Premiums, co-payments, and maximum out-of-pockets have to be reduced for lower income people to be able to afford valuable coverage. Using a minimal flexible spending account approach employers can structure employee contributions to be tax deductible, which increases affordability.

Any health insurance product design consists of four elements:

- When coverage starts,
- What services are covered,
- What amount is paid for covered services; i.e. usual and customary, contracted or a fixed fee,
- What the out-of-pocket costs would be.

Most employees have a period of at least 30 days after employment before they are eligible for health coverage in order to process paperwork and payroll deductions. There can also be an additional period before pre-existing conditions are covered. This is referred to as a pre-existing condition exclusion. The pre-existing condition exclusions are intended to prevent individuals from only getting health insurance once they are diagnosed with a health problem. To ensure that they are only used for this purpose, the

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[4] HRSA Illinois State Planning Grant, *Final Report to the Secretary,* Pg. 2. In addition to the Illinois project, many additional references and studies have reinforcee the issue of affordability.
[5] The Lewin Group, Inc., *Insurer Workgroup Report*, Pg. 6
[6] Includes premium costs; Wm. M. Mercer. *Arizona Basic Health Benefit Plan: A comprehensive Review*, pg. 11
7 Department of Health and Human Services, *The 2001 HHS Poverty Guidelines*, http://aspe.HHS.gov/poverty/01poverty.htm

federal Health Insurance Portability and Accessibility Act (HIPAA) prohibits group insurance from having pre-existing condition exclusions for individuals who have been continuously covered for 18 months without a 63 day break in coverage. If an individual has not been previously covered, a pre-existing condition may be excluded for up to 12 months (18 months for individuals not enrolling at the first opportunity).

The recommended product would have a 30-day waiting period and a maximum 12-month pre-existing condition exclusion for non-HIPPA eligible individuals.

Services that would be covered, if medically necessary, include:

- Preventive services
- Physician office visits
- Hospital services
- Home health
- Ambulatory surgery
- Emergency room services
- Prescription drugs

Excluded services would include:

- Organ transplants,
- Experimental treatments,
- Gender change procedures,
- Reversal of sterilization, and
- Infertility treatment for groups under 25 employees.

Transplant surgeries are very expensive and are performed on a relatively small number of patients. Therefore transplants would not be covered to reduce the cost of insurance with minimal effect to the total population.

Experimental treatments are excluded by most health insurance policies. Medical research is supported through a series of grants, federal subsidies and other mechanisms and not by insurance premiums. Once a treatment is accepted as an appropriate protocol for a condition, it is then covered by insurance and paid for by the insured population.

Infertility treatment is a mandated benefit for groups of 25 or more employees, but is not required for groups under 25.

Other services that are often included in health insurance policies, but may be excluded for affordability purposes include:

- Mental health,
- Chemical dependency,
- Vision, and
- Dental.

It may be desirable to provide some mental health and chemical dependency under a managed care arrangement that would keep cost down while providing effective benefits. There are some health care professionals who believe that providing effective mental health and chemical dependency care can be offset by decreases in medical spending for the adverse medical consequences of these conditions. Also, policy makers may decide that coverage of non-orthodontia dental services for children is appropriate, if it can be included without adversely effecting affordability.

In-network services would be paid at the contracted amount. Prescription drugs would be covered based on a formulary that would include an alternative for most therapeutic categories, but may include only generic drugs except for individuals who are allergic or have adverse reactions to the generic alternative. Two or more tiers of co-payments would be charged based on the formulary.

If mental health and chemical dependency are included, they would be provided through a managed care arrangement with an organization specializing in mental health care management and treatment.

Products would include an in-network and out-of-network component. HMO coverage would be offered on a point-of-service basis with out-of-network services offered with higher co-payments or with coinsurance applied. Non-HMO products would have different in-network and out-of-network coinsurance applied. Maximum out-of-pocket expenses are for in-net work services only and emergency room copay is applied even after maximum out-of-pocket is reached.

Cost sharing would be structured based on family income with changes in cost sharing at approximately 185%, 250% and 350% of the FPL. The cost sharing structure is summarized in the following table. Families below $27,000 (approx. 185% of the FPL) would pay minimal co-payments, deductibles, and coinsurance. Deductibles, co-payments, coinsurance etc. would be highest for those with incomes over $51,000 (approx. 350% of the FPL). The structure results in almost first dollar coverage for those under $37,000 and a high deductible plan for those over $37,000. Preventive services are covered with a small co-payment without regard to the deductible. That is, preventive services are covered even if deductible levels have not been met.

The definition of preventive services would have to be specified in detail but would generally include:

- Well baby care,
- Vaccinations,
- Periodic physicals,
- Pap smears and prostate testing, and
- Sick office visits.

Employee Cost Sharing by Income Level

Approx. max income		Monthly Premium		Preventive Service Copay/ Deductible		ER Copay **	Deductible*			Coinsurance		Max In-Network Out-of-Pocket	
Lower Limit	Upper Limit	Single	Family	In	Out		Single	Couple Parent +1	Family Parent +2	In-Net	Out-of-Net**	Single	Family Couple
N/A	$27,000	15%	15%	$5	$40	$50	$100	$200	$600	0%	20%	$400	$800
$27,000	$37,000	30%	50%	$10	$40	$75	$500	$1,000	$1,500	20%	40%	$1,000	$2,000
$37,000	$51,000	50%	75%	$20	$40	$75	$1,000	$2,000	$3,000	20%	40%	$2,000	$4,000
$51,000	N/A	TBD	TBD	$25	$45	$75	$1,500	$3,000	$4,500	20%	40%	$3,000	$6,000

* Deductible does not include preventive services

** After maximum out-of-pocket Emergency room copay is still effective (waived if admitted)

PURCHASING POOLS

Purchasing pools have been attempted in other areas of the country with mixed levels of success. The experience of other states can be used to sculpt an approach that has a good chance of success in Illinois.

The advantages of purchasing pool arrangements include:

- Economies of scale if a large stable population is covered,
- Efficiencies from standardized benefit designs and administrative procedures,
- Purchasing power to contract with providers and/or payors,
- Ability of small employers to offer choice to employees, and
- Potential to lower costs using state or federal subsidies or through the use of a reinsurance mechanism that spreads the cost of high risk individuals over a larger population.

In order to be successful and generate the advantages of a purchasing pool, it must be self-sustaining and have high consistent membership. Excessive turnover in membership will increase administrative costs and potentially healthcare costs as well if members join only when they need care and leave when they are healthy. The purchasing pool will become unaffordable if it attracts only the high cost members or if small employers do not join until one of their employees or employee's family has a health problem.

Examples of purchasing pool experiences include the Health Insurance Plan of California (HIPC), Texas Insurance Purchasing Alliance (TIPA), and the Council of Smaller Enterprises (COSE) in Cleveland Ohio.

The HIPC in California is now operated by the Pacific Business Group under the name "PacAdvantage." The HIPC originally did not use insurance agents. Once it began to do so, only a small number of agents participated. As a result, 75% of small employers were unaware of the purchasing pool. The HIPC did not reach the employee participation needed to realize the economies of scale that were needed to reduce costs[8]. This became especially clear when spread over up to 19 different carriers throughout California. Even though the expected cost savings did not materialize, the HIPC remains a viable program. Some other purchasing pools used more liberal underwriting and rating rules than the rest of the market and therefore attracted a large percentage of high risk individuals resulting in high cost within the pool. HIPC's viability stems, in part, from the fact that it was not a target of adverse selection because of its use of the same underwriting rules found in the rest of the market. The HIPC is also successful because of its ability to provide a choice of plans to employees of small employers.

TIPA also fell short of its potential. It was initially marketed directly to small business, but its small marketing budget was insufficient and it soon moved to a strategy of using brokers. Unfortunately the brokers in Texas directed the healthier lower risk groups to the private insurance market leaving the higher cost groups in TIPA. This, along with

[8] Millimiman USA, August 27, 2001, 12

adverse selection within TIPA that resulted in the higher benefit options becoming unaffordable, caused enrollment to reverse and the pool to fall short of its original objectives.

In the history of health insurance purchasing pools, COSE is seen as the one success story. COSE only contracts with two carriers and does not get bids from other carriers. Eighteen plans are offered to employers who then select the plans offered to their employees. Additional administrative fees are collected from employers to fund COSE staff, who currently do all marketing, enrollment, billing and collection. COSE historically has not used agents. Much of COSE's success, covering 60%-80% of the Cleveland small group market, is attributed to its local focus and relationship with small employers. Building on this success COSE is now expanding into other cities in Ohio.

Purchasing pool lessons learned include[9]:

- Provide a key role for brokers to educate small employers and promote the purchasing pool,
- Do not structure products with more liberal underwriting or rating rules than found in the market in general,
- Provide products that are attractive enough to cause a significant population to purchase coverage and stay with the pool,
- Limit the number of payors who participate to maximize the economies of scale and contract leverage with providers, and
- Run the pool privately either at conception or once it is established.

The proposed purchasing pool would offer a limited number of products specifically designed to be attractive to small employers. Underwriting and rating practices would parallel the current market. Also, each employer would choose the products and benefit level to offer employees. The products employers offer their employees would have similar benefit levels. For example, even if multiple deductible levels were available within the pool, there would only be one deductible level offered within an employer.

The number of payors participating in any area would be limited. Payors would be selected based on their ability to offer multiple plans (HMO, PPO etc.) and their financial soundness.

Purchasing pools can be organized locally or state-wide. However, local pools have better leverage with local providers because the members and local providers can come together with more of a sense of community. State-wide pools have a larger population to spread costs across and they have the ability to contract with centers of excellence for higher cost less frequent conditions. Centers of excellence are providers that have been identified as having improved outcomes in specific conditions such as cancer treatment. Contracting with these providers would allow payors to provide the highest quality treatment at a discounted price. Through a statewide reinsurance mechanism it may be

[9] Millimiman USA, August 27, 2001 makes these points as well a other studies of purchasing pools, see bibliography for more references.

possible to combine local or regional purchasing pools for financing and managing high cost low frequency cases. Reinsurance premiums for high cost conditions or individuals would be paid to a state reinsurance pool that would then pay for and manage these high cost cases.

A small staff would be required to implement the purchasing pool and provide ongoing support. This would require staff knowledgeable about the benefit plans available. Contacts to provide information for plans and brokers in the general operation of the pool would be needed. In addition, broker and public education must be available throughout the implementation process. Implementation activities include broker and public education. Ongoing, the purchasing pool staff would be available to assist brokers in answering small employer questions.

The pool would be open to all employers with 2-50 employees. Employers would be required to contribute either 70% of all premiums or 100% of employee premiums and 50% of dependent premiums. There would also be a requirement that 75% of employees within a business participate. There would also be a three year commitment to participate. During the first thirty days of operation, all employers that meet the above criteria can join. After the initial period, employers can only join if they have been providing health insurance coverage for a minimum of one year. It is possible that a mechanism could be designed to allow employers to join without the one year minimum coverage. However, the employer would have to pass higher underwriting standards and would not be eligible for any available subsidies or reinsurance coverage for one year after joining.

REINSURANCE POOL

Reinsurance is a mechanism for taking very high costs and spreading them over a larger population. This smoothes out swings in the cost of health care from year to year and from group to group. However, care has to be used to ensure that the reinsurance premium charged to relatively health groups is not uneconomical in relationship to their expected reinsurance claims under the agreement.

There are three aspects to consider when structuring the reinsurance agreement:

- What payments are reimbursed by the reinsurance,
- What groups would be pooled together for reinsurance premium determination, and
- What funding would be available besides an actuarially determined premium

Reinsurance can cover expenses over a specified amount (attachment point) or for specific conditions or individuals. Attachment points can be set at a dollar amount (e.g., $50,000 for a person per year), at a percentage of expected claims (e.g., 125% of average expected claims), or at a dollar amount for a group (e.g., $5,000 times the number of employees). Reinsurance can also be for specific high risk individuals previously identified as having health problems or for high cost conditions such as cancer or organ

transplants. Combinations of these arrangements are also available. For example, cancer can be carved out in one reinsurance contract and expenses in excess of $50,000 can be covered by a second contract excluding any expense for the carved out organ transplants.

The cost of the reinsurance can be financed by premiums from groups in the state sanctioned purchasing pool. Using state regulatory authority, it is theoretically possible to finance some part of the cost of reinsurance beyond the purchasing pool to the total small group insurance market and beyond. Also, it may be possible to obtain subsidies using other state and federal programs for the low income or uninsurable populations. If the reinsurance pool is subsidized, the cost of the reinsurance is, in turn, decreased.

Reinsurance spreads some of the cost of higher risk individuals to healthier groups. Premiums can be determined so that groups with high risk individuals pay a higher premium with a lower subsidization than healthier groups. The premiums should be structured so that healthier groups do not drop out of the pool leaving only the high cost groups participating.

SUMMARY

In summary, the social good of reducing the uninsured is well recognized, but affordability stands in the way. The three mechanisms expanded on in this paper include:

- A small business health insurance product structured to be affordable and attractive to employees,
- A small business purchasing pool structured to maximize cost effectiveness and participation, and
- A potential reinsurance mechanisms to help mitigate the effect of high cost individuals.

Each of these mechanisms could have an impact individually, but the largest impact may be achieved from implementing them in combination.

The next step is to solicit reactions from small employers to these ideas.

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